MONTANA
Department of Public Health & Human Services

January 1, 2006
Montana Medicaid Notice
Outpatient Hospital

January 2006 Outpatient Prospective Payment System (OPPS) Code Editor (OCE) Changes

Medical and Procedure Visits or Multiple Medical Visits on the Same Day

- Under limited circumstances, medical visits on the same day as a procedure will result in additional payments. Using modifier 25 with an E/M code indicates that a medical visit was ***unrelated*** to any procedure performed that day with a status indicator of "T" or "S." Modifier 25 is used ***only*** when the patient's condition required a significant, separately identifiable E/M service the same day a procedure was performed. If the procedure was related to the medical visit you may not use modifier 25.
- Multiple E/M codes on the same day on the same claim may receive additional payment if they are for different revenue centers.

  Multiple E/M codes on the same day with the same revenue center will not receive additional payment. Please remember that Medicaid does not use condition codes. Adding condition code GO to these claims will not result in additional payment. If you have two distinct medical visits on the same day (such as two ER visits, one for a broken arm in the morning and one for chest pain in the afternoon) the claim must be separated onto two claims and sent to DPHHS, Hospital Claims Resolution, P.O. Box 202951, Helena, MT 59620-2951 for review and separate payment.

Changes to Coding and Payment for Drug Administration

- **Billing for infusions and injections.** Bill first hour infusion codes C8950, C8954 and 96422 after 15 minutes of infusion. If you provide different types of infusion that may be separately billed (e.g. intra-arterial and intravenous chemotherapy) in the same encounter you may bill a first hour for each different type of infusion.

  Infusions lasting less than 15 minutes should be billed as intravenous pushes.
- **Subsequent infusion hours.** Bill additional hours of infusion codes C8951, C8955 and 96423 only after more than 30 minutes have passed from the end of the previously billed hour. In other words, to bill an additional hour of infusion after the first hour, more than 90 minutes of infusion services must be provided. Bill one unit for each additional hour of infusion.
- **Concurrent infusions.** Concurrent infusions through the same vascular access site are ***not*** separately billable. Include any charges associated with the concurrent infusion in your charges for the infusion service you bill.

- **Intravenous or intra-arterial push.** Bill push codes C8952, C8953 and 96420 for services that are less than 15 minutes or when a healthcare professional administering the injection is continuously present to observe the patient.
- Services that are ***not*** separately billable:
  - Preparation of chemotherapy agent
  - Use of local anesthesia
  - IV start
  - Standard tubing, syringes and supplies
  - Access to indwelling IV, subcutaneous catheter or port
  - Flush at conclusion of infusion

Modifiers

- **Modifier 59.** Use of Modifier 59 on chemotherapy and non-chemotherapy drug infusion indicates a distinct encounter (59 is used for a different session or patient encounter, a different procedure or surgery, a different site or organ system) on the same date of service. For chemotherapy administration or non-chemotherapy infusion the following criteria must be met to use this modifier:
  - The drug administration occurs during a distinct encounter on the same date of service as a previous drug administration.
  - The same HCPCS code has already been billed for services provided at a separate and distinct encounter earlier on the same day.

  Modifier 59 is ***not*** to be used when a patient receives infusion therapy at more than one vascular site of the same type (intravenous or intra-arterial) in the same encounter. Do ***not*** use Modifier 59 when an infusion is stopped and then started again in the same encounter.

  In cases where infusions of the same type are provided through two vascular access sites of the same type in one encounter, bill two units of the appropriate first hour code for the initial infusion hours without Modifier 59.
- **Modifier 52.** Modifier 52 must be used to report a service that was partially reduced or discontinued and did not require anesthesia. A physician may discontinue or reduce a procedure for any number of reasons. The decision to do so is at the physician's discretion. Modifier 52 is used most often to identify reduced or interrupted radiological and imaging procedures.

  Effective January 1, 2006, a 50 percent reduction will be made for those services to which Modifier 52 is appended.

Modifier use is monitored through post-payment audits. Any claims paid in error due to incorrect use of modifiers will be recouped. Deliberate misuse of modifiers to enhance payment may result in referral to the Montana Medicaid Fraud Control Unit.

This is a general guide from the January 2006 CMS Hospital OPPS update. For detailed billing directions please refer to current American Medical Association CPT books, current CCI edits (Version 11.3 of CCI edits is included in the January 2006 OPPS OCE) and provider manuals on the CMS website at http://www.cms.hhs.gov.

Contact Information

For claims questions or additional information, contact Provider Relations:

Provider Relations toll-free in- and out-of-state: 1-800-624-3958
Helena: (406) 442-1837

Visit the Provider Information website:

http://www.mtmedicaid.org